

**METROROCK**  
69 Norman St. Unit #9  
Everett, MA 02149  
617.387.7625

MetroRock Staff Only:  
Week(s): \_\_\_\_\_  
Indoor/Outdoor

**HEALTH HISTORY AND EMERGENCY TREATMENT AUTHORIZATION**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_  
Medical Insurance Policy No.: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_  
Primary Care Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

**In case of emergency while I'm at MetroRock Climbing Camp, please contact:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Relationship to participant: \_\_\_\_\_  
Alternative Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**Participant Medical Information**

Please explain "yes" answers to the below questions

(Does/Has) your child:

- ◆ Had a broken bone \_\_\_\_\_ -----
- ◆ Have diabetes \_\_\_\_\_
- ◆ Have asthma \_\_\_\_\_
- ◆ Suffer from seizures \_\_\_\_\_  
Date of last: \_\_\_\_\_
- ◆ Been diagnosed with a heart murmur \_\_\_\_\_
- ◆ Suffered from joint pain/injury \_\_\_\_\_
- ◆ Been dizzy during or after exercise \_\_\_\_\_
- ◆ Had emotional difficulties for which professional help was sought \_\_\_\_\_
- ◆ Had back problems \_\_\_\_\_
- ◆ Felt chest pain during exercise \_\_\_\_\_
- ◆ Wear glasses or contacts \_\_\_\_\_
- ◆ Ever been knocked unconscious \_\_\_\_\_
- ◆ Ever been hospitalized \_\_\_\_\_
- ◆ Ever had surgery \_\_\_\_\_

Is your child currently taking any medications (prescribed or otherwise): YES / NO

Yes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have any known allergies or dietary restrictions: (food, medications, bees, insects, other): YES/ NO

Yes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe any current conditions that require medication, treatment, or special restrictions or considerations while at camp:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby grant MetroRock and its agent's full authority to take whatever action they deem necessary regarding my child's health in the case of an emergency where I am unable to make a timely decision. I fully release MetroRock and its agent's from any liability in connection with those decisions. I grant permission for emergency treatment by a private physician and/or hospital or emergency health care facility staff, under the same circumstances as above, if needed. Any such action will be taken in my best interest.

Printed name of Child: \_\_\_\_\_

Printed name of Parent/Guardian: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

**CAMPER IMMUNIZATION RECORDS ARE REQUIRED TO ATTEND CAMP.**